Meaningful Use Workgroup
Draft Transcript
February 5, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good afternoon, and welcome, everybody, to the meaningful use workgroup. This is a subcommittee operating in public, and there will be opportunity at the end of the meeting for the public to make comment. Let me just remind workgroup members to please identify yourselves when speaking. Let me do a roll call now.

(Roll call taken. Attendees present: Christine Bechtel, Paul Tang, Art Davidson, David Lansky, Deven McGraw, Charlene Underwood, Neil Calman, George Hripcsak)

Did I leave anybody off? Okay, with that I'll turn it over to Paul Tang and George Hripcsak.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great, thank you. Well, let's see. We only have an hour and a half, so we had left off with a couple outstanding questions and then some other clarification section that we didn't get to during our face-to-face. Let me start out with a general question. We did send out, and I don't know whether everybody had time to read it. We did send out a draft stage of the letter up to the point where we had agreed on things, and I wondered if people had any comments on that. There was one committee recommendation listed as number one that was discussed but not necessarily voted on, at least to my recollection. Maybe I'll start with general comments on is it in general accurately reflecting what we discussed in our face-to-face so far.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, it's Christine Bechtel. If we're going to go through the details of the letter, I did have some areas where my takeaway was a little different, and then other things that we should probably discuss.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, I do too, Paul. There are a couple of areas. Most of it was very good, and then a couple I didn't track with.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, that's true. This is George. Excellent, and we just need to go through it quickly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, so let me bound this from a time point of view until my 10:30, and then we can work on it offline if it requires more than that. Let me start with recommendation one. We had originally, as this group knows, not reported any thresholds except for initially we said that 100% CPOE for ambulatory and 10% in the hospital. Other than that all of our recommendations included just reporting only. As you know CMS's NPRM did set, and so wanted to go back and see whether this group had an agreement on whether we agreed with thresholds. Then as a separate question what would they be versus reporting only.

Neil Calman – Institute for Family Health – President & Cofounder
This is Neil just to let you know I've joined.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks, Neil.

Christine Bechtel – National Partnership for Women & Families – VP
It's Christine. I think we had some discussion of this at the last workgroup meeting, and it certainly is different than my understanding, so I am not in favor of the approach of only reporting and not having some thresholds as a global matter.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, others?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, I share that. I wouldn't want to make this a policy statement. I have my own biases, but we should have thresholds where we can and as a default, and if we can't, reporting is a reasonable solution where that makes sense.

Art Davidson – Public Health Informatics at Denver Public Health – Director
This is Art. I agree with both of those comments.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The NPRM had an algorithm by which they determined the threshold or something they proposed, and one is if it does involve exchange of data, some kind of interface, then the threshold was set at 50%, and if it was all self-contained within EHR, it was set at 80%. At least that was my reading of it. Is that something you would like to keep intact? Is that acceptable, and if so, we actually can just remain silent or endorse that.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, it's Christine. It is, but I would just add the other threshold pieces whether it's already part of a certified EHR from, I think, 2008 or 2009. I forget, but that was in the rule, and so I thought those were good criteria.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This is Charlene. I've actually got some concerns because we've done a … in terms of trying to understand how to calculate some of these thresholds, so let me give you a few examples, and I've got some actual solutions for some, but others we can't get, and some of the solutions you probably won't like. Let me give you an example of two, 10% of CPOE orders. We don't want to create a burden where they have to count their paper orders, so one of those solutions should be able to count the threshold of 10% is … your electronic orders make it so that 10% of those are ordered by a licensed professional, but then you're going to have to specify electronic orders to make sure that your base of your denominator is what you want it to be. Again, that's one variation, so because these structural measures have not been NQF certified and there's not been a process to actually go through and agree upon a strong robust measure set, there's going to be a lot of confusion and clarification and all that type of thing necessary in the industry to get to these threshold measures.

I'll give another example, 50% of lab orders. When we were trying to calculate what's 50% of lab orders that are sent in that are numerical, which labs are you talking about? Again, some of those labs … in the hospital settings go out to external lab systems, threshold systems, so out of the 50% orders, do those count? Do those not count?

Again, that whole ability to be able to figure out what's in the numerator and the denominator, the recommendation is you state here are the 300 tests that you're looking at, and of those, count those and determine if they've got numeric data in your database. You might be able to do that. My recommendation is before we go forward and say, as a policy we can say we would like to do thresholds. I would think in the first phase if we could report the denominator and start to get the numerator, and that's going to be a challenge in some cases, too, that's a huge, huge first step.

I would like to get the thresholds, but I think we have to be very sensitive to the cost to span the timeframe because none of these thresholds have solid definitions, and everyone's going to interpret them differently. Again, how they're defined today is they're negotiated often with the payer or whoever's doing the performance measurement.

Christine Bechtel – National Partnership for Women & Families – VP
Charlene, it's Christine. Is that the case with every single one, or is there a number where a threshold, like, particularly in the EP setting and also in the hospital setting where a threshold is okay? I think what I'm really asking is should we deal with this in the context of the specific measures rather than making a global statement up front?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
My take would be NQF has an HIT utilization committee now in place that's going to define qualified structural measures. We should endorse that. We should participate in that and follow in that and use that as our go-forward strategy so we get to the structural measures, but those will be tested that they're obtainable. They're not too much burden, all those kind of things that NQF tests and that we can calculate, but the measures now that are defined are measures that CMS had to define to set the bar, and you're going to get this kind of confusion in the industry, and there are no means for us to come together and define what that might look and feel like.

David Lansky – Pacific Business Group on Health – President & CEO
This is David. My bias is that we're primarily a policy committee, and we should support the policy that says thresholds are advisable as a policy direction, and CMS has the job of operationalizing the … that are going to be use, as Charlene describes, and I don't think in our committee given our time availability we can try to resolve this measure by measure. We're better off communicating a policy encouragement to CMS and letting NQF and other bodies work out the details.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, my concern is, I'm not fighting your policy; it's just the implementation of it in the timeframe because of the lack of all that other stuff is a challenge.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can I offer a denominator and just see if this doesn't meet a test of low burden? The denominator would be claims, so in other words, orders that are chargeable, i.e. for which you submit a claim would be the denominator, so there's no paper counting. You obviously sent something out, and that's the denominator, and if you have 10% of those chargeables that were ordered by the authorizing provider, I'm not happy with just letting a nurse enter everybody's orders, for example, but by the authorizing provider, that's the threshold you would meet.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We worked through that one, Paul, and the challenge there was not a one-to-one correspondence to how you build versus how you count orders because orders explode into panels and all those types of things, and how their billed necessarily doesn't correlate to, you'll get some percentage, but you're not going to

get necessarily a percentage that correlates and you can count on across the board because of that variation in billing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You don't think that 10%, that's why it was set so low. The 10% would accommodate those kinds of variants.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Because we've never done it, we've never tested it, we don't know that, and the same thing on the hospital side. We just don't know that, but we know there's a lot of variation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Respecting what David said, I think we do need to not get hung up on one. On the other hand as part of being concrete and useful to CMS, I think they need somebody give them, so they proposed an option, and I think if we say that there's an alternative, we actually have to propose exactly how they would propose it as an operational way of doing it. That may be an exercise we have to go through at a later time. Remember we're presenting our draft to the full committee for comments. Then we still have time to turn it around before the final letter. In other words we will stick with thresholds. We will try to figure out whether we have an operational definition of these thresholds that would be useful for CMS.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, the thing that we thought in at least the first stage is getting some, we actually support getting some number because it starts to get to your baseline. You know if you have 0 or 100. It's not perfect, but at least, so, the endorsement, if you can't get to a threshold, report the numerator. You get to some basis of a measurement.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, but this group is saying that they want to have thresholds, and now our challenge then is to try to find a way that could be consistently defined without a …. That's where we need to get to.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But that means because there's no, but you don't get anything in stage one. Don't you think you have to say something?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, I think we're going to have to take this at a different call and perhaps actually get definitions. Is there one definition, say, for the denominator that could cross all measures or not? That would define sort of our challenge.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, but I think that's a transparent—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we're going to have to do this later, okay? Recommendation 2 is to reinstate the progress note. Are there any comments about that?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, Paul. It's George. I think the advice we got was that if we wanted to put them back in we need to specifically address the comment that they're going to be done anyway. What we're addressing here is their comment that it's not directly related to quality, but the other half of it was that they said that it was

going to be done anyway; therefore, we don't need to mandate it. Therefore, we have to state that we do not believe that it will be done anyway and that a substantial number of eligible professionals may remain on paper the way it's currently written. That has to be part of our explanation why we want it back.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's fair. Is that something you'd like to help draft?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Sure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you. Any other comments? Were the recommendations accurate? Recommendation 3 was to essentially draw up the core measures, and we spent a lot of time in this. We sort of enumerated the criteria we saw for a core measure. Remember, the core measure is every EP and hospital would have to do this, and we actually found out that the three that were proposed did not meet the criteria.

In addition we looked at our own, well, we actually just had some examples we proposed. We didn't actually say these should be core. One was CPOE, and that actually became a core measure because everybody had to do it to get the incentive anyway. We have the same problem with high-risk medications in the sense that we don't have clear criteria for that right now. The confirming insurance was our third example which would have been core, but it was actually eliminated in the NPRM. As a consequence based on our attributes of what would be suitable for core measures and the ones that were proposed did not meet those, we recommended not having those core measures in stage one, anyway.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, it's Christine. I think I would frame this slightly differently, and I think that I would suggest we consider rather than dropping the core measures, I think it was David that talked about the fact that this is where we at. They're really catch-up measures, but that's sort of the state of where we're at right now, but that they are important areas, so rather than saying drop them, I'm wondering if we can say integrate the core measures into every specialty possible. That way they're reflected in the specialty groups wherever it's appropriate based on that specialty, but they're not completely dropped from the criteria at large.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we're saying the same thing, Christine. You're saying put it where it's relevant, and that sort of is different from "core measures applying to everyone."

Christine Bechtel – National Partnership for Women & Families – VP
Yes, so it is a different approach, and I think we recognize that a different approach is needed, but I also think I'd strengthen the language around the bullets to basically say the concept of core measures is a good one, and we think that CMS should send a clear signal that this approach is going to come down the pike in future years, but at the same time we need to work on finding those measures that meet the criteria that we've outlined here in the bullets. I really reacted viscerally to the whole drop them because I think it sends the wrong message.

Neil Calman – Institute for Family Health – President & Cofounder
This is Neil. I wanted to just, let me take a shot at this, maybe even a slightly different way. When we first started in one of those first slides where we put up sort of the basic principles of what we were concerned about, reducing cardiovascular disease by X amount and whatever, there were sort of these fundamental underlying healthcare goals that we articulated in the beginning. My sense is that that's sort

of where the core measures idea came from. It's not that it's just like measures that sort of run across everything. It's really, do we have any sort of fundamental statement about what the major issues are that affect people in America and what we could do about them.

I think it's worth calling out some of those things, obesity and hypertension, obesity related to the BMI, hypertension, but calling them out as sort of going back to the principles, and then showing how they run through all of the measures and criteria and stuff that we have. In other words I think what sort of ends up being missing is kind of the sense that there are some overarching themes that we're concerned about, medication safety, obesity, hypertension are sort of major public issues, and when you just kind of drop them into those big lists, you kind of lose that sense. I think it would be worth calling it out in that way, not necessarily as core measures, but as sort of underlying principles.

David Lansky – Pacific Business Group on Health – President & CEO
This is David, Paul, and I agree with both of those comments, and I think since we're providing comments to CMS, this is a good place for us to say we have reason to not support the approach that's drafted with the core measures, but the concepts Neil just described, we still feel strongly that that approach to the overall enterprise is worthwhile, and we would encourage CMS to find a way to address those outcome goals or core competencies that would apply across the board. I'm partly afraid, while I agree with Christine's tactical solution, I'm a little afraid of it sort of looking like PQRI all over again, that we end up with every specialty kind of goes off and does its own thing, and we don't have some sense of convergence toward national health strategies. I hope we can advise CMS in preamble language or comment language to keep working on finding a way to address these overall goals.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we can actually accommodate both of those concepts in this feedback. One is as you suggested making sure we don't lost the concept that we are shooting towards improving health status on some priority health outcomes in some priority health outcomes areas, and that can go in the preamble so that we don't lose that sentiment which was part of the core measures idea. Yet, for stage one we couldn't find things that met all of the core measure attributes, and in Christine's suggestion, go ahead and not lose some of these things by putting them in areas where they're appropriate. Would that help solve both, I think one, not lose the focus on health outcomes by moving that sentiment, setting those principles up in the preamble, and two, not losing the specific measures even though we found that they didn't meet all the criteria and apply to every EP or hospital.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, are you saying that we should have something called either shared or common measures, and they are put essentially in a table, and then they say which of the subspecialties have to do it so that you don't end up with elderly medication in the pediatrics, but they're set aside? Is that what you're saying, like a separate table that has here's the high priority things we have to work on together, but then they say it goes in this, this, this, and this table?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In a sense that's what they have laid out, so it—
George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But now the core goes to everybody. We don't want them to go to everybody. The ones that they called core are shared, but they're not really universal. They're not truly universal.

Neil Calman – Institute for Family Health – President & Cofounder
I think it's less important who they apply to, although I think that's got to be clearly specified in the measured. What I'm suggesting is that we rearticulate those basic overall goals, and then we can maybe

with an asterisk or something we can highlight the measures that really reflect those overall goals so that they really run through the document. Do you know what I'm saying? I think the preamble's a good place to put some of those overarching goals and then allow the measures to kind of support that, but I don't think we need a separate place for those measures.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Neil, then, what would our recommendation be exactly?

Neil Calman – Institute for Family Health – President & Cofounder
Our recommendation would be that the preamble articulate the major issues that we're calling out which are the major sort of epidemics, I guess, of our society, smoking, hypertension, diabetes, medication errors, the four or five things that we're talking about. Then through the document the measures that reflect those principal areas are called out with an asterisk or something like that to show that a lot of these, it sort of highlights the point that a lot of the specific measures are really tied to these national sort of outcome goals that we're trying to achieve.

Art Davidson – Public Health Informatics at Denver Public Health – Director
This is Art. I like the way that this is moving. I would rather than saying that we couldn't find one, we're specifying where they are with this asterisk that Neil's indicating so that we don't have to say we couldn't find them. We just found a different way to distribute these measures in the rest of this document.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In a sense the concept of core was that everybody would be expected to meet them. I think you're using in the terms of high priority or something like that or …. I think we need to articulate the map back to health priorities, but I'm not sure that we actually came up with things that fulfilled the core that applies to everybody. Neil's suggestion is we try to emphasize the notion of high priority areas like from the NPP and map those to individual measures.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right, I agree with that entirely. I'm not disagreeing. The only thing that I'm disagreeing with is that for us to state we could not find core measures. We're now expressing these core measures in shared responsibilities distributed in the various tables by specialty.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, not exactly because the definition of core meant that it applied to absolutely everybody.

Art Davidson – Public Health Informatics at Denver Public Health – Director
That's what I think rather than saying we couldn't find any, we defining it differently.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's fine, so that's the same as saying we'll use a different word, like …. I think we have what we need for this recommendation, and it can be edited like the two concepts that were proposed. Should we move onto recommendation 4 was to reinstate the stratified quality reports by disparity of variables. Any problem with that? Recommendation 5 was to go back to the maintain up-to-date rather than a process measure, and in keeping with a suggestion is recommended a way of how to assess that. Recommendation 6 was to reinstate the advanced directives. Recommendation 7 is reinstate the patient's specific education resources.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, I think the piece. It's a little bit different (This is Christine.) than what we talked about the way the recommendation got couched. EPs and hospitals should report on the percentage of patients for whom, what we had said was they use the EHR to suggest patient's specific education resources.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then how would you measure that? That's where you need to be specific, too.

Christine Bechtel – National Partnership for Women & Families – VP
Going to have to be at a station. I don't know how else you would measure it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How then would you even audit? For every at a station, there has to be an operational way to audit.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, so that's why, this is fine how it is. I think it, well, let me ask you, how it's written, how would you audit it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You can have "patient instructions" or some kind of things, and that can be captured in the EHR. To the extent that there are patient instructions that were driven off the patient's problems or things related to the patient context that would show up in the numerator.

Christine Bechtel – National Partnership for Women & Families – VP
I think I'm having trouble following if that's the same as what I'm suggesting. What we have here is actually broader which is fine by me. I just think we had talked about it a little bit differently, but that's fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Anybody else want to comment on that?

Christine Bechtel – National Partnership for Women & Families – VP
Great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Christine, you were saying try to capture whether something was suggested.

Christine Bechtel – National Partnership for Women & Families – VP
Somehow it's EHR-enabled, right? The whole reason we were talking about this in the last workgroup meeting was because people were struggling to see the connection between health IT and patient's specific education resources, so the way 7.1 is technically worded, there isn't a link. It's different from our discussion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I see what you're saying, okay. If we made it more specific and said we could measure that the EHR displayed for the provider patient-specific information that could be dispensed in a way, that's capturing your concept?

Christine Bechtel – National Partnership for Women & Families – VP

Yes. Like I said, I think it's fine how it is, but if it's more likely that it's going to be accepted if the exact verbiage links back to EHR, then I think you should put that there. On the other hand, we do link it in the text below, so I'm okay with either approach.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's actually interesting. The recommendation text actually is more "outcomes oriented" than process, so what you said was actually more process, EHR did something. Here it's measuring did the patient get something.

Christine Bechtel – National Partnership for Women & Families – VP
Right, and that is something that is specific to their condition.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's correct, and by definition, it had to have been done by EHR; otherwise, it'd be very inefficient.

Christine Bechtel – National Partnership for Women & Families – VP
Now, the other thing I would say is I think we did talk about signaling, so maybe at the end of the paragraph signaling that in 2013 the EHR should be able to provide patient-specific information because there are standards in the pipeline now that should be part of future certification.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we can signal in our 2013 kinds of recommendations.

Christine Bechtel – National Partnership for Women & Families – VP
Well, no, I think it's important to signal now since there are products on the market that actually do this today, but would meet 2011, but also make it so that a provider, this is one less thing we're going to have to worry about in 2013. I don't see any harm in signaling that in this case.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It says what then?

Christine Bechtel – National Partnership for Women & Families – VP
That the committee recommends that CMS provide a clear signal that in 2013 the EHR should be able to provide patient-specific information from the EHR because there are standards in the pipeline now that should be part of future certification. I can email that in.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, but I almost think that's already in here for 2011. One way they can fulfill this is through and probably the easiest way is for them to have this available through EHR. Maybe we can deal with this offline, but I may be missing the point of signaling because it's already in here.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I can try to clarify.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any other comments on seven?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I actually have a question on this. What I don't understand is, and again, taking the inpatient environment, the patient's taken care of. There's a care plan that's generated. At the conclusion what

you want to do is generate their discharge summary that's dependent on what went before. In that case there are some prerequisites, stuff you would really like to have in place to be able to do this. To do this out of context, that seems like you're creating a process that's independent of what the real process should be. In that ambulatory setting, you do have clinical documentation in place, so I'm struggling with how, I think it should be signaled that this is coming. I support the fact it should be a patient context-specific recommendation. Doing it in 2011 seems to be not on a glide path, and it's going to require some rework to come to it out of context.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I just would say this was something we took a vote on in the last workgroup. I don't want to put it back on the table.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Charlene, this is just patient instruction in the hospital setting on discharge, and so you have plenty of information to base it on.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
You don't have a care plan.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
…

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Is that a gap?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is saying this is the way you would give heart failure instructions to patient with heart failure rather than print it on every discharge form. That's what we're trying to avoid.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This is not one that hospitals can't do, but it's just that if you look at the process that you really like to do it in it's usually in context with care planning.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I don't understand why that's an argument against it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, neither do I.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's a 2013 because care planning's in 2013. It's not even 2013 yet for hospitals.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, we're saying, so one of the process measures is to give patients who have a diagnosis of heart failure discharge instructions that reflect their diagnosis of heart failure. A way that people are meeting this requirement is to print it on every discharge form no matter whether they have heart failure or not. The way you would meet this criteria would be to only print it on discharge instructions for people with heart failure.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Okay, but that assumes you know what heart failure is, and in most systems today in the inpatient setting, the problems are not codified in that way. That's coming. If you would like to do it right, you would like to do it both on the fact that you've got some elements in place to help guide you down a patient context-specific education resource. You can just print off discharge summaries today, but without some additional data entry it can't be patient-specific. We'll have a med list. You'll have an allergy list, and in some conditions some level of a problem list, but in 2011 this early stage one, it's going to be tough to do. I'm not going to fight over this one because they'll get around this one, but I don't think it's going to, it's not really what we'd like to do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
As Christine pointed out, we did vote on it, and there are still some of us that are struggling with why wouldn't the discharge diagnosis be available.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Because if you look at in hospitals today, in problems, there are nursing problems, physicians don't enter problems. Problems are not codified. It's a huge problem. They're codified in knickknack NANDA, but they're not in SNOMED until after the fact you code them in medical records, so how can I generate discharge instructions if I have to wait for medical records to put the ICD-9 or 10 code in. There's no problem definition.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
You should get it off the coded problem list which is a requirement in 2011.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't have a coded problem list. I have an ICD-9-based coded problem list, and to look at the requirement, again, today there's a huge problem in hospitals getting to a codified problem list in 2011.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What I don't understand is everyone is required to leave the hospital with a discharge summary instruction. On that it must say your discharge diagnosis. Correct?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm not sure it has to say that. It says you've got heart problems, and you have a piece of paper, and you carry it out with your instructions.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
If that's what's happening, then we definitely need this in 2011.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm not disagreeing that we need this. I'm saying the data elements necessary to make this easy and part of the flow will not be in place until a little later on in the process because the information I think you need to generate it won't be codified, is not codified today. You don't have nurse documentation in place. You don't have care plans in place. That's where nursing diagnosis is included. The codification of problem list doesn't exist yet.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Charlene, maybe let's focus again on the question. The discharge instructions, in my mind, must have discharge diagnosis, the thing that the patient walks out with. That's what happens on paper. It's hard to understand why that wouldn't be in the electronic health record.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Today if you look at what's typically in the record you're going to have an ICD-9 code, and many times that's coded after the patient leaves.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But they do have to leave with that information.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't think that's the process. Today's process is not that. Today the diagnosis is in an annual chart. You know what the diagnosis is. You know what piece of paper to pull. If the process needs to be going key in the diagnosis based on what's in the chart and pull the paper, that's what the customers will do, but it won't be there until they actually do the process.

Christine Bechtel – National Partnership for Women & Families – VP
I don't understand. If you don't know what's wrong with the patient, how can you give them a discharge summary?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
You have a med list. You have an allergy list, and from there you can detect a lot about the patient, but typically today in hospitals, diagnosis is not codified when you're in the hospital, and if it is it's codified in a knickknack, some other standard.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think a lot of us are very interested in this topic. Let's make sure we discuss it, and maybe we can even do some of this by email. I think you probably have to show us, Charlene, how someone can leave the hospital without knowing their diagnosis because what at least the … on the call are saying is part of the requirement. It's hard to understand why that wouldn't be known. Let's take that off since obviously there's something that we're not understanding.

Christine Bechtel – National Partnership for Women & Families – VP
But, Paul, we're not making a change to the letter or deleting a recommendation or anything that we've already voted on, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's reinforce that. Are people happy with the way it's currently stated? Hello?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We're here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Anybody not?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I have to vote no.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, and we'll help drove down on that so that we all are better informed.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Recommendation 8 is the efficiency measure, to reinstate that. Are there changes to that? One thing I didn't recall, recommendation 8.1 that one of the five be on efficient diagnostic test ordering. Was that something we put in there?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, my notes say yes, Paul. This is Christine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Other people.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, I recall that, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so do we want to vote on that? Maybe that's the piece that I'm missing.

Christine Bechtel – National Partnership for Women & Families – VP
Sure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How many would like to have at least one of the five clinical … rules address the patient diagnostic test ordering.

Christine Bechtel – National Partnership for Women & Families – VP
This is Christine. I vote yes.

David Lansky – Pacific Business Group on Health – President & CEO
David, yes.

Deven McGraw – Center for Democracy & Technology – Director
Deven, yes.

Neil Calman – Institute for Family Health – President & Cofounder
Neil, yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Art, yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
George, yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Charlene, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, it's unanimous. There we go. Recommendation 9, we talked about his glide path.

Josh Seidman – ONC

Paul, just one other thing. This is Josh. One of the questions is whether in terms of the generic issue if that might be best tackled in terms of the regulations, the APA, if that might be best tackled by putting it on amid the drug formulary checking because that's something that is actually in the NPRM criteria, and it might stand the test of the APA better.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I think that's a really smart approach. It's Christine.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I'm sorry. What does APA stand for?

Christine Bechtel – National Partnership for Women & Families – VP
The Administrative Procedures Act which basically is the thing that says if it's not in the comment rule to begin with and the proposed rule, you can't add it in, in the final.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Now I remember. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The proposal is instead of looking at generics where possible, it's to say check whether it's consistent with drug formulary. Now, that presents a problem because generic is known by everyone. What the formulary is electronically, what the formulary is for this patient and knowing that patient's plan. You know, there's thousands. That can be a different issue in whether you can have accurate information about that, accurate either from the knowledge base meaning does someone actually even know what's in the plan and accurate from what plan is this patient on. That presents an additional problem.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, aren't they getting the formulary information from SureScripts or RxHub, or I guess they're merged now, but I think I'm not following what you're saying.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There are two things to know whether this prescription fits that patient's formulary. One is to know what health plan that patient is on, and two is to know what's the current formulary for that person's health plan, and you have to have accurate and timely information on both those pieces. That turns out to be logistically very hard.

Christine Bechtel – National Partnership for Women & Families – VP
I think that's what SureScripts does.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
They don't know anything about this patient's plan at the time of service, and actually, I don't know how reliable SureScripts is in terms of timeliness, and somebody else may know on this call.

Deven McGraw – Center for Democracy & Technology – Director
This is Deven. We did get some testimony that the formulary information that they do get, I can't recall whether it comes from SureScripts or through some other mechanism like a practice management system, but it's frequently inaccurate.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, that's been our experience.

Deven McGraw – Center for Democracy & Technology – Director
That's a long-term problem that's got to be fixed.

Christine Bechtel – National Partnership for Women & Families – VP
For the purpose of the recommendation, maybe we can say we suggest this come back in, and we note that it is related to formulary checking, and then we're going to have to figure out how to operationalize it separately.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, that's not as helpful as CMS because this is the challenge as Deven heard is people don't know how to do this correctly because of the inaccurate and incomplete information that they have. Despite their intent it is hard. It's just like the interoperability, the exchange of health information today well-intentioned folks can't do it because of things out of their control.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we originally, and, Josh, are you saying this is, what we're saying here because when we discussed it, I thought we might've even been, when Tony was on the call, that because, and in fact we pointed out to the page because we talked about using generic medications, that's still within scope.

Josh Seidman – ONC
I'm sorry. I don't think Tony was on the call at that point, and I don't think he is now. Is that correct?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's correct.

Josh Seidman – ONC
He would be the one who would need to clarify that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You're ruling it out, I guess I'm asking.

Josh Seidman – ONC
Yes, but I'm not really the right person to ask. I think it's probably a call for CMS.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, but what I'm saying is we can point it out, and if CMS has to rule it out, they have to rule it out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, so recommendation 8 as it is, is to go back to our original proposal. This is a known thing. You definitely rely on these databases being up-to-date, etc. If it's within scope, then it is, and if it isn't, then they can rule it out, but proposing something that would be both burdensome and for which well-intentioned people can't comply with would be problematic I would think.

Neil Calman – Institute for Family Health – President & Cofounder
There's one other piece of this that, are we talking about the specific issue of the EHR, the generic medication piece, or just sort of in general, I think, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Didn't get that question.

Neil Calman – Institute for Family Health – President & Cofounder
On the EHR generic piece, one of the things that I'm concerned about is that for people that have had systems implemented for a really long time those percentages of medications ordered or generic or other kinds of order kinds of things may be built into the systems already that really have to be changed. You're going to reorder medications, if 90% of your medications are now in your systems as brand names, that requires a considerable amount of reworking.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The other thing to look at, and I don't know whether someone on this call can address. The pharmacies fill generic where available anyway unless written as DAW, so I think most people who do not exclude that will essentially have a high score.

Neil Calman – Institute for Family Health – President & Cofounder
I think the point here to me is that because of the generic substitution rules by almost every company and everything, to me this is more of a patient quality issue than it is an efficiency issue. I don't think you're going to save a lot of money by writing generic because most states, I guess, at this point have generic substitution laws, and most health plans require it, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, different point though, Neil. We wrote it as that was our intent to prescribe cost-effective generic medications when they exist, and what that meant is if there's—

Neil Calman – Institute for Family Health – President & Cofounder
Per drug class.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, right, yes, but that is a measure.

Neil Calman – Institute for Family Health – President & Cofounder
Okay, sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That is under the control of the physician.

Neil Calman – Institute for Family Health – President & Cofounder
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's see if we can make progress. Right now the proposal on the table is to keep recommendation 8 as is which reflects how we put it in the matrix, and it's subject, of course, to whether CMS can include this. Is that acceptable to people?

Neil Calman – Institute for Family Health – President & Cofounder
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any opposed? Let's continue where we left off with our conversation at our face-to-face, then. We had a couple homework assignments. One was dealing with the all-or-nothing threshold. Charlene, is that something you were—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, I did a draft on that. I can kind of walk through it. I didn't send it to the whole group because I just literally finished it, so I'll walk through what I did and what some of the concepts were behind it, and maybe you can react to that. Would that be okay?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
If you look at the meaningful use rule, and I did it more on the hospital side. That's why I put a … measures. Eligible professionals have 25 objectives and measures, 8 that are yes or no, and 17 that'll have numerator and denominators. Hospitals have 23, 10 with yes or no and thirteen with numerator and denominators. They all have a set of performance measures that they're going to have to do. EPs have two measure groups, and eligible hospitals have 43 quality measures. Then I took what we agreed upon last time as our strategic direction—focus on outcomes, use the federal policy … to develop meaningful use that aligns with adoption policies, balance achievability, meaningful use should be staged to provide a glide path so you avoid dead ends, and prioritize the use of resources to provide support to areas where there's the greatest need. That's kind of a strategic direction.

When we look at this one the sense that it's all-or-nothing is there are just currently in the rule too many points of failure. You could do absolutely everything right, meet 25 of those objectives, and then get 79% of the problems in, and you fail. There are a lot of points of failure, so the issue was how can we look at perhaps making this process a little bit more flexible.

The … objectives and thresholds, so we kind of walked through. I have a customer focus group that's pretty representative of cross-section of the hospitals. We've got more than one product, diversity of products. I don't go to all the rest of the vendors. I could do that, but in the timeframe that was tough, but these people have been looking at this stuff and providing feedback pretty consistently.

We went through each of the measures for hospital, and we looked at with something that they thought should be a mandatory one to get going or is it something that is dependent on something. You either can't do it because there are problems with it today. These are pretty, some advanced users, and they talked through what those problems were. I kind of documented that, or is it something that they should, and I'll talk to problems specifically, they should get going with in 2011, but make it the real thing in 2013. Then there are some others that are dependent on those to make them even better in 2013, so it's a net. I ended up with some mandatory and some optional based on that category. For instance, the hospital one I ended up with 13 mandatory and the remainder that were optional and couple ones that I suggested deleting or we need to discuss more, but I'm not going to, for purposes of this call, I'm not going to go into all that.

For one of the ones, and we kind of walked through this, the recording the vital signs we looked at the growth chart. Well, in hospitals it's included, but typically, when children come into the hospital, they're dehydrated, so actually, doing a growth chart might not make sense. If you're going to do failure to thrive,

it doesn't make sense to do a growth chart because there's such a rare case that ever comes into the hospital, so there are some of those recommendations that came out of the process.

… talk about problems, they are very committed that problems is an important thing to give in an electronic record. It's not there, either in nursing, so the codification is the real problem, not that they shouldn't do it. Most of them felt they should get problems in there anyway they could in the early stage, and then work on the codification in the second stage, but that has ramifications to ….

The other thing we did was we went down and looked specifically at the quality measures. I guess it's brand new in the hospital space. There are some hospitals that are electronically dividing their measures today. The ones you can get come out of processes like … and again …. The rest of them come out of processes that are in our stage two, such as nursing documentation and/or physician documentation. It's definitely possible to do, but there are dependencies in later phases in terms of the measures.

What the recommendation was, well, we want to give credit for going in the right direction. We definitely want to simplify, add clarity, and reduce burden as much as possible, so therefore, we don't want to, for instance, make them count paper copies of orders or paper copies of requests. Although, in some cases like when you want to … produce an electronic company of my medical record, there's always software in place they can do that with in medical records, so there are some of them that are achievable.

What the recommendation was at the end of the day was in the rule you can't get less payment if you don't do it all, but what you can do is you can actually lower the bar. The recommendation was something like require, in this case we identified 13 mandatory, and we can argue over that, that they have to do, and then have them do one more optional one because you want to send a signal, so leave them all there, and they have to do one more. Maybe your top line at the end of the day is you have to meet 80% of the objectives. Then you also want to communicate that those objectives are going to become mandatory in the next phase because some customers can do them today. Some customers can't, so you set a glide path basically. As much as you can, have them attest to those capabilities rather than calculating numerator and denominator for the reasons that I mentioned. Then as much as we can qualify measures to reduce ….

That was kind of the thought process we went through, but we drilled down, we looked at what made sense, what didn't make sense operationally, and I'll give you a really concrete example of one of them. To be able to be able to produce a take-home document for a patient, you'd like to include the discharge summary in that which, typically, discharge summaries are narrated. They're transcribed. They're done after the fact. The better case would be, and this is what some hospitals are doing today. They had a quick discharge summary that they put into the system right at discharge such that the patient carries home a piece of paper or an electronic copy of that discharge summary, and they can make that possible in terms of using it. Well, we don't have physician documentation in place until the second stage, but that makes a lot of sense as a way to do it in a kind of go-forward path.

Basically, that was the level of the conversation, those things that didn't have dependencies we think should be mandatory. Those things that would be better off later, we made optional and would include those things because some facilities will be able to do them, but lower kind of bar to the combination of those to 80 or 90 or some other percentage. That is the thought process behind it. We didn't drill down. The ambulatory may not flow the same way, but it was a way to make reporting, at least in the first phase, more of the way to do it as opposed to a threshold as well as provide some threshold in terms of the number they have to achieve. That was kind of the concept behind what we were looking for, but we can try a different approach, but that seemed to make some sense given the real operational perspective.

Neil Calman – Institute for Family Health – President & Cofounder
This is Neil. I'm not going to comment on the specifics of what you said, Charlene, but I think that the idea of recognizing the fact that the all-or-nothing piece on the criteria is problematic, has great legitimacy. There's almost nothing else like that, joint commission, NCQA, whatever it is, there's always an opportunity to recognize that you're going to lay out 20 goals, and people are not going to get 100% of them. Every comment that I've seen, whether it's from attorneys or industry or providers or whatever, all highlight that same issue, so I think it's going to come up, and I think CMS is going to deal with it because they're going to get an overwhelming number of comments about that. I think if we could give some good guidance there, it would be very worthwhile on our part.

Christine Bechtel – National Partnership for Women & Families – VP
I agree.

Neil Calman – Institute for Family Health – President & Cofounder
My comment would be I think, again, this is an opportunity to call out the things that we think are really critical and to make a subset of them mandatory. I like that idea. I don't know what the right number is or which the right ones are, and I'm not even sure we should do that, but I think it's going to be essential to sort of do something like that because it's going to be impossible for people to hit every threshold on every measure. I think it's going to be discouraging and keep people from wanting to go towards this process.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Other comments? I think I'm sympathetic with this approach, too, and I think Charlene outlined a process by which you decide, well, why would you label something mandatory versus optional to be mandatory later which becomes the built-in signal.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We left all those ones on the list, so we didn't pick any off. We just made things that were dependent optional because some will be able to do those things.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It prioritizes the whole list. Now, that argues for who's going to do that, and unfortunately I think if this were to be our recommendation, the most effective way for it to improve its probability of success is for—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Us to do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Us to do that because—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think we need another discussion, though, to go through that stuff.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, and I didn't do the ambulatory piece. I just kind of drilled down, and we did two calls on the inpatient piece.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
More discussion on the concept of it is out of scope for us to say, Congress' intent was it is either going to be paid, you're going to get the money or you're not. There's no you get 50%. What we're suggesting

maybe in scope is to say here is the criteria, and by the way there's this mandatory section and there's this signal section. Maybe that's a good way of saying it, and that helps kill two birds with one stone in the sense that we wanted that glide path anyway. That's a way of putting a glide path in the first stage criteria.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We suggested even that they do some of those signal ones, that they're required to do some of the signal ones.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I see, yes, so there's the mandatory. Then you choose from.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That just makes it more complicated. I'm not sure I would—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Do that, but that's fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Other people's thoughts on let's say the concept first, and then we have to figure out how does this get done. Does anybody else want to speak on behalf of it or against the idea?

Christine Bechtel – National Partnership for Women & Families – VP
Paul, it's Christine. I think it's hard to make a judgment. It's a very interesting approach assuming I understand it, and I think it depends on stepping back and looking at what the 80% really amounts to. If it really does amount to significant progress in the areas that we know are the most critical, then I think I'm open to it. I think it's an interesting approach. We should keep it flooring.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In support of that as a process for getting to a recommendation on which would be mandatory, which was optional, maybe since we went at this thinking that it would be all or none basically, we in theory implicitly try to hit just the really high-priority and the mandatory and what we were thinking about. Now, learning more things about what's really out there and what are the products, etc. may have changed our mind on some of these things, so one way to do it is instead of going through each one and say yes, no, and what score is to work backwards and say, well, which ones truly are not mandatory. Do you see what I'm saying? You get the same bucket, but you approach it in perhaps a more tractable way, so look at all the requirements and say which ones should not be mandatory.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Maybe I'm just fooling myself, but it feels a little bit more tractable than to say let's go through each one with a blank slate.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, and I used more of the glide path rule as our determining factor between optional and, you know, that what was doing would not require you to do something ahead of what was logical in terms of implementation, so I used glide path a lot as my criteria for what was optional.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any of the people who haven't spoken yet want to weigh in?

David Lansky – Pacific Business Group on Health – President & CEO
This is David. I just want to make sure if we relax some of these to optional that the mandatory set, whatever we call it, captures all the core competencies on the glide path so to speak.

Christine Bechtel – National Partnership for Women & Families – VP
David, it's Christine. Are you suggesting like, for example, there's got to be at least one mandatory measure in every area of the original matrix? My obvious concern is going to be that we just made all the patient-family engagement stuff optional.

David Lansky – Pacific Business Group on Health – President & CEO
No, absolutely, so it's not only those outcomes' domain, but also whatever underlying functional competency is associated with the measure. I don't have in my head what those, maybe some of the care goals, but somewhere we have implied, for example, medication management is a domain we wouldn't want to leave off.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me just get a pulse of the group. Probably what we should do is put this in front of, at least what I'm hearing so far is it's a valid enough idea that we should put this in front of the committee, get a combination of CMS's ruling on is it within scope, do they have the latitude to do this. Secondly, is this what the policy committee would like us to further explore? If so, then the sense of the group that I wanted to get is do we have time to do an intense, and who knows, it might be a face-to-face again that last week of February to meet our March 1 deadline, or I could even ask CMS whether we could get a relaxation of that, but at any rate it would be yet another intensive activity to put forth the recommendation on what's mandatory and not.

Art Davidson – Public Health Informatics at Denver Public Health – Director
This is Art. I would feel more comfortable if we knew what those mandatory things were or outline them for CMS because it could get to be abused.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
First, we've got to see whether the concept is, one—

Art Davidson – Public Health Informatics at Denver Public Health – Director
… the concept, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, but I'm saying before we did more work because I think it's a large amount of work to be thoughtful, yet if it is a good direction, and most of us think it looks like it's a good direction, it's maybe a very key piece of determining how many people either go for it or qualify, but I think we need to spend the requisite time doing it well.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, and if you can lower bar in terms, if the threshold stuff isn't doable, then that changes the bar, too. It's a multivariable problem if you will.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I think I'd feel more comfortable if we could do some intervening work between now and the policy committee meeting before the policy committee meeting so that even the example that we present meets some of the requirements that David already talked about. I just am really concerned about putting things in the public domain that leave out big sections of priorities that are important. I think we need to add because we need to do the EP stuff. I know Charlene just did the hospital stuff so far, so maybe we could do that work offline to come up with the right example ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You don't think it would sufficient for us to say, I don't think the people on this call would let it happen that we eliminate one category just because, I don't think the purpose is to get just 80% of all of the measures and objectives. It is to find things that from a feasibility point of view or glide path kind of perspective may not be mandatory in stage one. Do you see what I'm saying? I think we've almost excluded the possibility of eliminating categories as getting to 80%.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Definitely.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right, and I—

Christine Bechtel – National Partnership for Women & Families – VP
What I'm saying is it depends on how you introduce the concept to the full committee because if there is a slide as an example that lists a bunch of mandatory and optional measures, if you just describe the concept, fine, but I think if we put up a detailed example of a table that lists some measures and suggest which ones might be optional or mandatory, then without some additional work to make sure what that looks like is close, I would be reticent.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Actually, I sent Christine because I was supposed to be working you, Christine, on a version of this as well as Paul, but I wanted to get some … on it.

Christine Bechtel – National Partnership for Women & Families – VP
I'm talking about slide five, a slide that, exactly.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Exactly, right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Does someone want to work on the ambulatory version? I can see value in, now remember, we have limited time to present this. We have a full agenda for this policy meeting next week, so I can see walking through some examples of mandatory and some examples of optional/mandatory later just so committee members understand what does that mean and, yes, could that work. We'd need accompanying stuff on the EP side as part of our example only.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

You could put in there a recommendation that says you have to do one in each of your categories to, so there are ways to make it directional as opposed to, but I think when we … we're going to say we want to make mandatory something in common across both of them, like exchange of clinical information, right, because we want that consistent.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're going to want mandatory, I would think you would want mandatory measures in each of the domains.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, and those in common across both the domains if we can.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
If we can as a workgroup just have some eyes on whatever the slide or the framing is that's going to be presented to policy committee, that's all I'm asking.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What's the work assignment that translates into what you said?

Christine Bechtel – National Partnership for Women & Families – VP
Charlene has done this slide on the hospital piece as an example. We need to do something on the ambulatory side, but I think your only talking about listing four, five, six examples and not presenting the entire matrix of functional and quality measures. I'm okay with that, but I think having some consideration of what are the principles that govern what's mandatory and optional is important, including what we've already talked about, but I think somebody probably needs to take a shot at what those might be. It would be great if as a workgroup we could circulate that a little bit with a really quick turnaround before it goes to the full committee.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think you and Charlene were on point for the homework. Do you want to come up with the set of guidance which we just mentioned, one in each category, but I think it's actually more than that, but a set of guidance to frame how we would approach this and then just a few examples to say, well, here's something that was mandatory which for this reason we would turn it to optional/mandatory later? That would at least give the committee enough of something to just discuss the concept.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, except that I've got about 20 hours committed next week to ONC, so I have a little bit of a time crunch.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I could work Neil if Neil would take … to do the ambulatory side. I could share that with him. We could at least do that topic, but the principle piece, we need someone probably to help with it. Christine, I don't know if I could just interview you and write them down and send them back to you.

Christine Bechtel – National Partnership for Women & Families – VP
No, I'll figure out a way. There are always weekends and late—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And a snowstorm, right?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, right.

Neil Calman – Institute for Family Health – President & Cofounder
Maybe we could set up just another call to do that for next week. Is that possible?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, I think, Christine, you're going to have to tell us, and we'll have to work around you.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, we can do that offline, yes. I didn't know if Neil's thing was to say the call was the three of us or as a whole workgroup.

Neil Calman – Institute for Family Health – President & Cofounder
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
I was thinking maybe the three of us.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, yes, that's easier.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Before we delve into scheduling on this call, we only have 20 minutes left. Are we ready to move on? I think this is very helpful, and it was very helpful, Charlene, for you to put that together both as a proposal and examples.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay, thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The other homework assignment we gave to us and probably none of us did it to the extent that we asked which was to put in writing the five different proposals for how to measure patient reminders. The overall concept was originally we wanted to find a way to measure that patients got specific reminders to their context, and what got put in the NPRM is that for patients over 50, did they get some kind of reminder. That was a fairly big step removed from where we were in our recommendation.

The challenge then is how would we operationalize what we were after which is patients would get patient-specific reminders. One example, the way we had it in our matrix was that, the matrix said send reminders to patients per patient preference, and by the way that was to make sure that they could get it on paper if that's what they wanted for preventative or followup care. The measure would be the percent of patients who did receive their reminders for preventive or followup care for which they were eligible, so the percent of patients who receive reminders about preventative services for which they were eligible

that pertain to them. If you had an encounter with someone of any age that was due for something, they had a reminder about it.

Neil Calman – Institute for Family Health – President & Cofounder
I don't know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You don't know—

Neil Calman – Institute for Family Health – President & Cofounder
The denominator on this is immeasurable in a way because what recommendations? Which recommendations are we talking about? Who's recommendations and at what age groups? I think if you kind of do that, the more comprehensive you want your recommendations to be, the worse you're going to look or the higher the threshold you're going to want to achieve in terms of sending them out. Then we're also dealing with in-house stuff where a lot of recommendations could be made face-to-face with patients. Some might be made through patient portals. Some might be made through, it's just what we're trying to do is get people moving in this direction, right, and I'm trying to figure out how to do that and still make a meaningful test of whether they really are doing it. This is so important. We've got to get this one right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That means we have to come up with a concrete example of how to measure.

Neil Calman – Institute for Family Health – President & Cofounder
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Operating just on the reminders seems a little bit, I agree with you, Neil, seems kind of silly. You need that coupled with some measure that you're trying to improve, so it's like the number of kinds who are up-to-date on their shots, if it's 100%, I shouldn't be sending a lot of reminders for shots, but if it's 0, I should be sending almost all the kids shots.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's why the qualifier was eligible. Let me give you an example to address Neil's problem. For patients over 50, they probably should have gotten a flu vac reminder or a colonoscopy reminder. If they got one of those two, you fulfilled this particular objective. Just to address Neil's, they could be open for 10 reminders, but no, we're saying do you use a functionality that improves health outcomes of reminding for things for which they're eligible?

Neil Calman – Institute for Family Health – President & Cofounder
Why don't we use the same approach that we're thinking about for the quality measures? Why don't we call out the things that we think everybody should be doing reminders on? What are the big public health issues? We say flu reminders because if you can figure out, if you can create the processes to do this, then we know that the systems are in place.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Exactly.

Neil Calman – Institute for Family Health – President & Cofounder
Why don't we call out the specific things that we think we want people to send reminders for?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We did. We used Exemplar, and we called out colorectal cancer screening, mammography, aspirin in high-risk cardiac patients, flu vac, so we did.

Neil Calman – Institute for Family Health – President & Cofounder
Why, go ahead.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Paul, you used a word that's not in this, the word eligible. It says send reminders to patients and 50% of all unique patients. It doesn't say 50% of all eligible patients.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You're reading from the NPRM, I believe.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, so … was eligible.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right, so that's one thing that we think they should put back, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. In theory I think we did agree that we would like to have patient-specific reminders be delivered by whatever mechanism the patient wanted, and that got taken out. Now, as we put it back in or recommend that it be put back in, we're looking for a way to operationalize it because that was the challenge. To follow the latest thread, Neil says, well, let's just pick on the things that are important.

Neil Calman – Institute for Family Health – President & Cofounder
That are connected to the important quality measures that we're going to do so that we're building a sense in people that there's some cohesiveness to this, that in order to improve quality, one of the things you do is do reminders. There's some cohesiveness to what this is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We did that in our matrix anyway.

David Lansky – Pacific Business Group on Health – President & CEO
Well, the reminders are specialty-specific. You end up with the same problem with reminders as for quality measures, and so what reminders should dentists send out, podiatrists send out, etc.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The ones that are relevant to their quality measures.

Christine Bechtel – National Partnership for Women & Families – VP
Which are only, what, three to five per? Is that right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That was the goal that was in the emporium, yes.

Christine Bechtel – National Partnership for Women & Families – VP
All right.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Paul, I'm sorry. I have to drop off. Let me know if you're going to have another session, thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, thanks.

Christine Bechtel – National Partnership for Women & Families – VP
This is Christine. I like what Neil is saying in theory. I think I need to go back and look at the quality measures and whether they're kind of appropriate and how much it leaves out because I think there's a lot of preventative care that they probably leave out and follow up, too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, there was a fair amount of preventative care measures for primary care as one of the "specialties."

Christine Bechtel – National Partnership for Women & Families – VP
I think they only have to choose three or five of them, though, right?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No, CMS chooses three or five I think.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
This is David. I'm actually not unhappy with the current 50% crude ratio because as a way to get started, I think … assumption whether 50's the right number or not is that to many populations, there is probably some responsibility to get the word out for patient-specific reminders. This was a crude way to capture using a capability that's embedded in the tools. I think trying to operationalize it in the way we just all want it with the way we all want to do is going to be pretty cumbersome.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But that's how CMS ended up here. I still wonder what an ophthalmologist is going to do with a 51-year-old in terms of 50% of them getting reminders necessarily.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
One of the criticisms about this method immediately was the under 50.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, but that's other problem. They were just trying to find a solution to the measurement problem.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Exactly.

Christine Bechtel – National Partnership for Women & Families – VP

But to George's point, if it's all appropriate patients, we'll say over the age of 21, then they could be sending, an ophthalmologist could be sending a followup, so something that says you've got to come back in a year. That's when your next indicated care is. Right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's correct.

Christine Bechtel – National Partnership for Women & Families – VP
I was fine—this is Christine—as it was written except the 50 years old threshold, so I was suggesting removing that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Again, they did the 50 just to get the probability higher and not putting the burden on everyone to figure out what's appropriate, that I want people to go through chart reviews to figure out how many were appropriate to get reminders. You could go to age 21 and lower it to 10%.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This is this whole problem. If there's some optionality in this, then your ophthalmologist wouldn't have to do it, but they might have to do something else. Again, all-or-nothing thing, but I think it's challenging this. We can make it the right measure for the right population and then add some optionality in here.

Christine Bechtel – National Partnership for Women & Families – VP
But, Charlene, if it ends up being impractical and people don't understand how to do it, they just won't do it. I think if it ends up being something that's optional, it's got to be actually doable and realistic so that people can choose it and they don't turn away from it simply because—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, I'm supporting that. It's just that some of the, we're challenged because of the two coming together in some cases.

Neil Calman – Institute for Family Health – President & Cofounder
We might be still in need of an operational definition. I'm still a bit rueful about losing the use of the EHR to create patient-specific measures. You can imagine a world where we use the same approach of just trying to do a sweep and see if an objective was met, but it could be met with or without an EHR, so that gives me heartburn. I'd like to challenge us again to try to come up with a practical way to go after the intent that we originally sought. Is that a fair request?

Christine Bechtel – National Partnership for Women & Families – VP
One of the things that we said was to have it be reporting on the percent of reminders sent for appropriate patients, but not have it be a threshold. Does that help?

Neil Calman – Institute for Family Health – President & Cofounder
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What—

Christine Bechtel – National Partnership for Women & Families – VP
I'm sorry, Paul, the exact language in my notes is percent of unique patients who received a preventive care reminder per their preferences and then a separate one that said the same thing, but it was a percent of any patients who received followup reminder per their preferences.

Neil Calman – Institute for Family Health – President & Cofounder
That you can see neither of those depend on the EHR. That where the heartburn comes in.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Right, that is.

Neil Calman – Institute for Family Health – President & Cofounder
This is Neil. Can I make one more plea that we tie this to the quality piece? I think there's an important signal that we're losing here that these are just not random things that people should just be sending out. I think if we're sending a signal that the specialists have certain quality measures, don't we want them to focus the reminders on the people that are failing those quality measures? Maybe that's the thing to say that people who are failing, that those folks who are in the denominator of their measures but are not in the numerator that 50% of those people get reminders, that they be able to send reminders out to the people that are failing their quality measures because anybody can, you could put a postcard in, and I can take any billing system and print address labels of everybody over 50, send them all a flu reminder, and right now that would meet the criteria.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's go back to assigning ourselves homework, but this time there's going to be a stick to it. We do have a call set up for the 12th, a week from today, to finish this workup. We wanted to get as much done as possible because we've got to write this stuff up, essentially, actually, we're supposed to turn the slides in the day before, and no one can present a new idea unless it's in writing.

Neil Calman – Institute for Family Health – President & Cofounder
What?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, on this subject. We all assigned ourselves the homework assignment of coming up with the operational definition, and that's what we're struggling with, so if we did our homework, then we would have better things, more concrete things to discuss. If we each of us want something to be discussed, it's got to be in writing to all of us so that we can discuss it.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I think that's a good idea. It's Christine. I can't be on that call because it conflicts with another scheduled ONC thing, and I'm wondering if it's possible for everybody to maybe send that in to Josh or to Judy by Thursday so that we can just compile it and send it back out to everybody so those of us who couldn't be on the call can weigh in ahead of time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Sure, I think that's a good idea anyway regardless of whether you're going to be on the call Friday. Yes, would that be agreeable to folks?

Neil Calman – Institute for Family Health – President & Cofounder
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
…

David Lansky – Pacific Business Group on Health – President & CEO
Paul, I think both Deven and I have a conflict with that call next week, too, so the whole call may be a little short in population.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so I guess we have to rework this. That's a challenge for ONC staff. If that's possible,

M
There are only a few of us on this. Should we talk about it now? Is that possible?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me ask a question then. First, who can go beyond this time which is about four minutes from now, and two, I think there's not too much to discuss about the clarification questions, and let me just check. How many people can go for another 20 minutes?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No.

David Lansky – Pacific Business Group on Health – President & CEO
I can't. No.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
George, no.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
George no.

Christine Bechtel – National Partnership for Women & Families – VP
I can try. It's Christine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, it's not fair since we already scheduled this call for a specified time period to all of a sudden make it—

Chris Weaver – Altarum
This is Chris at Altarum. I just have to speak up because there's actually another workgroup using this ….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, that's just a technicality.

Christine Bechtel – National Partnership for Women & Families – VP
Aren't we the center of the universe? I'm sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I guess we can't. If we shifted it an hour for the folks who can't make, does that help shift it an hour late, so from 12:00-2:00?

Christine Bechtel – National Partnership for Women & Families – VP
I'm tied up all day. It's Christine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How about the others who were, Deven and David?

David Lansky – Pacific Business Group on Health – President & CEO
We have an event here, and I can't even remember what the timeframe is, but I know it conflicts. We probably have to solve this offline.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, let's solve that offline. Let my try a couple things that I hope might be easy. Under the clarification questions, CPOE, I think one of the issues was when they went to the word licenses professional versus authorizing provider, that opened the door for any licensed professional to be entering all the physician's orders, and I seriously doubt that's what we meant.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, I'm going to sign off. It's David. Thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you have an opinion?

David Lansky – Pacific Business Group on Health – President & CEO
No.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
You want provisions? You don't want nurses entering physician orders and those kinds of things?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
That's correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We want the authorizing provider. The whole reason to have them enter the order is so they get feedback, so it's sort of you miss that step if you have an intermediary.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I understand licensed professional, you might have the pharmacist enter the medication order. That could be another issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's another out, right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, that's another out, but we say it's the patient's … because you're checking this stuff.

Neil Calman – Institute for Family Health – President & Cofounder
Paul, I think this is for them to figure out. I think the recommendation is that we find an ambiguous who actually needs to carry out each of the …, not just ordering, but data entry and everything, and if they want it to be ambiguous, that's fine, but they should know that it's ambiguous.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There are different types of orders, and it's very important I think if we're going to do this to specify the type of order. The authorizing provider, so a nurse is the authorizing provider for nursing orders.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But that's typically not CPA. You're talking physician order entry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's contradictory a little bit.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, for the nurse practitioner who's entering—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, NPN can do that, right, but a licensed professional who can write, the goal here was to do medication orders, right, at the end of the day. They can do the other orders, but you don't want to …. You want them to definitely get the meds in.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It looks like this wasn't the short topic. I think we're going to have to find another time to get together I suppose even if it's after the full meeting because it's possible we don't have time before the full meeting, but anyway, we'll work on that offline. Any other last minute items?

Neil Calman – Institute for Family Health – President & Cofounder
You want only new items in writing?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, I'm just saying it was that one where we failed on our homework assignment. That was just the stick after—

Neil Calman – Institute for Family Health – President & Cofounder
I still have a concern that I think we should deal with at some point which is that there are no requirements for eligible hospitals for their ambulatory care systems, and that's where a huge number of poor people get their care. Basically, you don't have to do, your ambulatory care providers can practice in the same old cruddy way they always have because all of the criteria we put on hospitals are for the inpatient side, and we haven't addressed the outpatient side of hospitals where millions and millions and millions of people get their care, especially poor people. I guess I'd at least get a reading on whether that's … or not so that if it is we can address it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm afraid that isn't in our scope.

Neil Calman – Institute for Family Health – President & Cofounder
Well, I think it may be because the types of providers are specified. The criteria are specified. It's just that crossover of criteria for ambulatory care in hospitals is not specified.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
They're not covered in the incentive program.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
…

Neil Calman – Institute for Family Health – President & Cofounder
Right, it's not in the incentive for hospitals to get their money. It doesn't have to be that the doctors in hospital outpatients get their money or that hospitals get extra money for the outpatient doctors. You understand what I'm saying?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, that's an interesting loophole for a loophole.

Neil Calman – Institute for Family Health – President & Cofounder
It's not a loophole. It's just that we're recognizing that hospitals don't just have inpatient functions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I get it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
All right, guys.

Neil Calman – Institute for Family Health – President & Cofounder
Anyway, I want that on the agenda.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, that's fair. I wonder if we could try to get a ruling from CMS ahead of time to see whether that is something we should do. Well, thank you, everyone, and we'll—

Judy Sparrow – Office of the National Coordinator – Executive Director
First, we need to ask if there's anybody on the public.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm sorry.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you check, please?

Operator
If you guys want to wrap up while we're waiting, go ahead.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Judy, I guess our challenge is to get another call on the book.

Judy Sparrow – Office of the National Coordinator – Executive Director
Right, Monday might be a good option, the 8th.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can't do that.

Judy Sparrow – Office of the National Coordinator – Executive Director
Let's just talk offline.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, we'll have to talk offline. Maybe a poll of folks, we might have to start with that. Could we do that?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, that would be good since it's so soon. I think we should try to do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All right, thank you. Anybody in the public?

Operator
We have no public comments.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks, everyone.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thanks, everybody.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Talk to you later.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay, bye.